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Disruptions and Adaptations: The Effects of COVID-19 on Contraceptive Services across the Humanitarian-Development Nexus

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The Women’s Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

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Cover photo: A selection of short and long acting contraceptive supplies in a facility in Mozambique.
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Contents

- Introduction.....1
 - Methods and ethics2
 - Limitations2

- Contraceptive service delivery disruptions, challenges, and solutions amid the COVID-19 pandemic2
 - Method availability3
 - Provider availability4
 - Contraceptive supplies5
 - Data collection and reporting6
 - Training7
 - Community sensitization7
 - Demand for services7
 - Barriers for marginalized populations8
 - Impact on adolescents8

- Contraceptive service delivery adaptations amid the COVID-19 pandemic.....9
 - Use of technology and telemedicine9
 - Multi-month supplies10
 - Task-shifting and sharing.....11
 - Community-based contraceptive information and service delivery and distribution11
 - Self-administration of DMPA-SC12
 - Integrated service delivery13

- Factors affecting contraceptive access and availability amid the COVID-19 pandemic13
 - Differences in disruptions and adaptations between humanitarian, fragile, and development settings13
 - Preparedness for sexual and reproductive health14
 - Prioritization of contraceptive and SRH services during COVID-19 response15
 - Using the MISP for SRH to guide service delivery prioritization.16
 - Using other guidance on adapting services during COVID-19.....17
 - Coordination18
 - Funding.....20

- Tracking what works now and in future emergencies20

- Discussion.....22

- Conclusion25

- Acronyms and abbreviations26



Introduction

On March 11, 2020, the World Health Organization (WHO) declared COVID-19 a pandemic.¹ Two weeks later, on March 25, the United Nations (UN) launched the Global Humanitarian Response Plan for COVID-19, issuing a \$2.01 billion appeal to combat COVID-19 in the world's most vulnerable countries.² At the time the response plan and appeal were released, COVID-19 was already wreaking havoc in the world's wealthiest countries, and poised to devastate countries facing fragility and crises, and exacerbate already critical humanitarian needs on a global scale.

Contraception is lifesaving, and is a priority health service in emergencies—as detailed in the 2018 Minimum Initial Services Package (MISP) for sexual and reproductive health (SRH). It should be made available at the outset of every emergency response, including epidemics and pandemics.³ Facing acute disruptions in movement, service delivery, and supply chains due to the COVID-19 pandemic, stakeholders rapidly adapted their activities to provide ongoing contraceptive services, developing and implementing innovations in preparedness and response in real time.

Between August 27 and October 3, 2020, the Women's Refugee Commission (WRC) conducted a series of key informant interviews (KIIs) with diverse stakeholders to document the impact of COVID-19 on contraceptive service delivery, service delivery innovations and adaptations to continue providing contraception during the pandemic, and barriers and facilitators to the provision of contraceptive and SRH services in COVID-19 preparedness and response in settings across the humanitarian-development nexus.

This series of KIIs is one component of a mixed-method landscaping assessment, which includes a literature review, a global contraceptive programming survey of implementing partners in humanitarian settings, two series of KIIs with stakeholders across the humanitarian-development nexus, and three case studies in diverse humanitarian settings—Cox's Bazar, Bangladesh,⁴ Borno State, Nigeria,⁵ and Cyclone Idai-affected Mozambique.⁶

In November 2020, WRC convened technical stakeholders from a range of settings and organizations to collaboratively develop actionable recommendations for governments, donors, researchers, advocates, and implementing partners to advance the availability and accessibility of sustainable, high-quality contraceptive services across the humanitarian-development nexus. These recommendations, as well as a synthesis and discussion of key findings from across all components of the landscaping assessment, will be available in January 2021.

1 <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen>.

2 <https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf>.

3 Inter-agency Working Group on Reproductive Health in Crisis, <https://iawgfieldmanual.com/>.

4 Women's Refugee Commission, *A Clear Case for Need and Demand: Accessing Contraceptive Services for Rohingya Women and Girls in Cox's Bazar* (2019), <https://www.womensrefugeecommission.org/research-resources/contraceptive-service-delivery-in-the-refugee-camps-of-cox-s-bazar-bangladesh/>.

5 Women's Refugee Commission, *Gap between Supply and Demand for Contraceptive Services in Northeast Nigeria* (2020), <https://www.womensrefugeecommission.org/research-resources/contraceptive-services-gap-nigeria/>.

6 Women's Refugee Commission, *Opportunities and Challenges for Contraceptive Service Delivery in Cyclone Idai-Affected Areas of Mozambique* (2020), <https://www.womensrefugeecommission.org/research-resources/opportunities-challenges-for-contraceptive-service-delivery-in-cyclone-idai-affected-areas-mozambique/>.

Methods and ethics

Between August and October 2020, WRC conducted 29 key informant interviews (KIIs) with representatives of UN agencies, government health authorities, international nongovernmental organizations (INGOs), and national nongovernmental organizations (NGOs) supporting or delivering contraceptive services in settings across the humanitarian-development nexus across regions. Respondents were identified using purposive and snowballing sampling and included representatives of one UN agency, eleven INGOs, five national NGOs, and three government health authorities from three countries. Among the UN agency and INGO respondents, 12 were based at headquarters, and 8 were working at the regional or country level. For the purposes of anonymization, data from UN agency respondents will be reported as INGO respondents. Twenty-three interviews were conducted in English. Six interviews were conducted and transcribed in French, then translated to English for coding and analysis. Transcripts were coded and subjected to thematic analysis using NVivo 12 Plus.

Upon securing verbal informed consent, interviews were recorded; recordings were deleted after transcription. All materials were stored on secure, password-protected devices. No identifying information about the respondent or their organization is included in this report or any product of the landscaping assessment.

Limitations

Researchers did not attempt to reach saturation, and findings may not be representative of all organizations' experiences providing or supporting contraceptive service delivery in settings across the humanitarian-development nexus following the onset of the COVID-19 pandemic.

Contraceptive service delivery disruptions, challenges, and solutions amid the COVID-19 pandemic

Across settings and organizations, respondents were nearly unanimous in citing disruptions to contraceptive and SRH service delivery by mandatory restrictions, including movement restrictions, lockdowns, and curfews. Many respondents reported that health facilities delivering contraceptive services were closed, at least for a period, as part of these restrictions. Multiple respondents representing different types of organizations working in humanitarian and development settings reported experiencing disruptions in contraceptive and SRH service delivery due to providers being redirected in response to COVID-19 and/or facilities being converted to COVID-19 treatment facilities.

Respondents across organizations and settings did not generally report disruptions specific to contraceptive services, instead noting that many SRH services were initially disrupted due to governments' perceptions that they were not essential or lifesaving, and were thus subject to the aforementioned restrictions. However, many respondents across organizations and settings reported conducting advocacy with governments to impress upon them the importance of SRH service availability, including contraceptives, and several respondents representing different types of organizations and settings reported that these efforts successfully contributed to the reopening of facilities and/or the resumption of SRH service delivery. For more information on governments' and stakeholders' prioritization of contraceptive and SRH services in COVID-19 preparedness and response, see "Preparedness for sexual and reproductive health" on page 14.



Method availability

Respondents were asked if they observed differences in the impact of COVID-19 on the prioritization or availability of different contraceptive services, including short-acting methods (oral contraceptive pills [OCPs], injectables, condoms, and emergency contraception), long-acting reversible contraceptive methods, or LARCs (intrauterine devices [IUDs] and implants), and removals of LARCs. A limited number of respondents reported observing decreases in the incidence or availability of permanent methods, but researchers did not explore the impact of COVID-19 on the availability of permanent methods in depth.

Several respondents, representing different types of organizations and working across a range of settings, did report greater reductions in or challenges to the provision of LARCs compared to short-acting methods, particularly earlier in the pandemic. This was reportedly due to limited availability of personal protective equipment (PPE), the required presence of the provider, and reduced flow of clients through static facilities. Additionally, a limited number of respondents reported their organization noted the issuance of or were following government guidelines on service delivery during COVID-19 that emphasized the provision of short-acting methods over LARCs.

However, we received a variety of responses, with many respondents across organizations and settings reporting that they were able to continue providing a diverse method mix. This suggests that the impact on the availability of different methods in a given setting was strongly influenced by the parameters of government restrictions and guidelines instituted in response to the onset of the pandemic, particularly in the earlier weeks or months.

Several respondents, representing different types of organizations and working in humanitarian and development settings, noted that many government and/or organizational guidelines directed providers to counsel clients that it is safe and effective to use LARCs past the expiration date set by the manufacturer, and they could delay routine removals and still be protected from unintended pregnancy. However, respondents emphasized that guidance did not prevent women who wished to have their LARC removed from being able to do so.

Some respondents reported that while providers continued to respect client choice, they did counsel women on the potential advantages of selecting a LARC during the pandemic to minimize trips to the health facility or in anticipation of future disruptions to access.

One INGO respondent based at the headquarters level, whose organization supports contraceptive service delivery in a large number of countries that include humanitarian and development settings, noted that from his perspective, the initial emphasis on telemedicine in the earlier weeks of the pandemic negatively impacted the provision of LARCs and accelerated the depletion of stocks of short-acting methods. Accordingly, he reported that, across settings, his organization ensured that different methods were made available through a variety of “channels” at the district level—largely by shifting the provision of OCPs, emergency contraceptive pills (ECPs), and condoms away from facilities to community-based distribution mechanisms, while ensuring that LARCs continued to be available at facilities. He stated that “[t]his hybrid approach of having the right mix between digital approaches for counseling, consent, [and] follow-up, using home delivery couriers to access specific products that could be self-used, [and] supplementing with trained staff in secure environments to provide clinical services, was the approach that we found had the most effect in minimizing disruption for services.” For more information on organizations’ use of technology and digital approaches for counseling and follow-up, see “Use of technology and telemedicine” on page 9.

Provider availability

Diverse respondents across organizations and settings reported that the availability of providers for SRH services has been disrupted over the course of the pandemic, negatively impacting the availability and accessibility of contraceptive services. Some respondents reported that movement restrictions prevented providers from reaching health facilities and, as previously noted, a number of respondents in a variety of settings reported that providers were diverted from delivering SRH services to respond to COVID-19. One respondent lamented, “Some of the staff have been moved to emergency response for COVID-19. So, this already creates a big gap, and definitely some clients visit the facility, and they might not get the services they need. And once a client [has visited the facility] for family planning, that means they really need it—they probably needed it yesterday.” However, other respondents reported that they did not experience challenges due to providers being diverted from SRH service delivery.

Many respondents—across levels and contexts—reported that at the outset of the pandemic, providers did not feel safe to work, especially as many respondents reported not having sufficient PPE in the first weeks of the pandemic. Multiple respondents reported experiencing disruptions in service delivery due to a lack of PPE at the outset of the pandemic; several respondents reported experiencing challenges sourcing PPE, and that PPE was very expensive. However, respondents did not discuss availability of PPE as posing barriers to contraceptive service delivery later in the pandemic.

Critically, multiple respondents also reported that providers and health workers were falling ill, and in some cases dying, due to COVID-19. Several respondents, representing a number of humanitarian and development settings, reported that providers went on strike due to the lack of adequate PPE. One INGO respondent, working at the country level in a humanitarian setting, said:

“Some of the health facilities closed because they lost their providers—they died. Others closed because one of their team died, so they struck. The first one [who died] was a midwife who was providing family planning. Most of the health facilities that we are supporting have only one midwife. So, if she died, the whole service would stop. It would be very hard to replace. The other big hospital which closed [had] a big strike because one of the...health providers in a maternity department, she died. All the other departments, including family planning, decided to ... strike, saying that they are not protected and no one cared about them.”

One respondent also noted that facilities were impacted when one provider tested positive for COVID-19, resulting in multiple staff having to isolate and being unable to work. Another respondent reported that provider availability decreased due to changes in how facilities were staffed to reduce the risk of COVID-19, resulting in fewer providers being available at a given time.

Notably, one INGO respondent working in humanitarian settings reported that while her programs did not experience significant challenges due to providers being diverted to COVID-19 treatment, she did observe that providers’ ability to conduct monitoring and provide supportive supervision for colleagues was negatively impacted by the demands of operating during the pandemic; the respondent did not specify whether this impacted the availability of contraceptive services.

Several respondents representing humanitarian and development settings discussed developing innovative solutions to provide supervision and support for providers, including providing “e-mentoring” and coaching via telephones or using WhatsApp networks to disseminate information on SRH services, and providing supervision via social media and WhatsApp groups. One respondent



also noted that these networks provided an important opportunity for providers to talk about stresses and concerns, and to provide one another with support.

Respondents across settings reported that conducting training for providers on infection prevention and control, in addition to the provision of PPE, helped to alleviate concerns and was an essential first step in adapting or resuming service delivery. Multiple respondents emphasized the vital importance of orienting providers to guidelines and adaptations, openly communicating about risks, offering psychosocial support, and providing opportunities for providers to ask questions and express concerns. One respondent, based at the headquarters level of an INGO working in humanitarian settings, noted that her organization was able to support providers at high risk for COVID-19 to stay home in a number of country programs, stating: "If [providers] feel comfortable and they feel confident, even putting their lives in danger, then our clients will feel comfortable, and they'll be willing to go to the health facility." She expressed that supporting health staff was a key challenge amid the pandemic, and that it would be important to prioritize "robust systems for staff care," including psychosocial support, moving forward. Respondents reflected that COVID-19 has drawn attention to the critical importance of addressing the psychosocial needs of providers and frontline respondents as part of efforts to ensure service continuity in emergencies.

Contraceptive supplies

Many, although not all, respondents across organizations and settings reported challenges with the availability of contraceptive and SRH supplies and commodities as a result of COVID-19. Movement restrictions and limitations—many of which were implemented at the sub-national, national, and international levels—disrupted supply chains, including for contraceptive supplies and commodities and PPE. Respondents described lockdowns and movement restrictions affecting the production and availability of supplies and commodities at the international level, the ability to import supplies, and the ability of staff to reach the warehouses to obtain and subsequently deliver supplies and commodities to service delivery points. One respondent noted that community health workers faced challenges accessing the contraceptive supplies they needed for their work as a result of movement restrictions.

Respondents also reported steep increases in shipping and transportation costs, and noted that PPE was extremely expensive given the high levels of global demand. Multiple respondents across settings reported experiencing disruptions in service delivery due to a lack of PPE, even when all other elements for service delivery were in place. Another respondent reported that they had to shift funding intended to purchase contraceptive supplies to purchase PPE.

One INGO respondent, based at the headquarters level, working in humanitarian settings reported an increased demand for Inter-Agency Emergency Reproductive Health (IARH) kits following the onset of the pandemic. Two respondents working in humanitarian settings from an INGO and a national NGO, respectively, reported that they attempted to procure IARH kits, but they were not available.

Diverse respondents across humanitarian and development settings discussed a range of solutions to address the challenges posed by supply chain disruptions, including assessing consumption data and redistributing supplies between districts and facilities according to demand and availability, and coordinating with partners to address stockouts and ensure continuity of services.

One respondent based at the headquarters of an INGO working in humanitarian and development settings reported that in many countries where his organization works, private sector and social marketing organizations may have had larger warehouses or stockpiles at the country level, and that his organization made arrangements at the global level with some of these organizations for staff at

the country level to obtain contraceptive supplies if they were not able to source them elsewhere.

Another respondent from the same INGO, working at the regional level in humanitarian settings, reported that in response to disruptions in the availability of IUDs, her organization used the cluster system to identify another organization that had IUDs, but were not able to provide them at the time, to borrow the supplies to continue providing the method.

Several respondents working with INGOs in humanitarian and, in some cases, development settings reported exploring or using local procurement options, given the difficulties they were experiencing sourcing from international suppliers, and/or getting products in country. One INGO respondent working at the country level in a humanitarian setting reported that although prior to the pandemic his program had not generally sourced supplies in the local market, it was able to procure supplies from a local supplier to ensure service continuity while waiting for orders from international suppliers to arrive.

Respondents' experiences addressing supply chain disruptions reinforced the critical importance of emergency preparedness for SRH. Diverse respondents indicated that they were able to ensure commodity availability during COVID-19 because of prior preparedness measures, including pre-positioning and stockpiling. Conversely, some respondents attributed challenges to a lack of these preparedness measures.

Data collection and reporting

Experiences with data collection and reporting amid the COVID-19 pandemic varied. Respondents largely reported that they had not experienced significant challenges with data collection due to COVID-19, but some respondents, representing humanitarian and development settings, reported that movement restrictions, poor internet connectivity, and lack of technology impeded collection, or prevented data collection from specific facilities, particularly in areas where data collectors could not reach service delivery points or staff were not able to reach their offices to input data. One respondent reported that data collection was disrupted because data collectors were not initially included in the organization's "orientation" on COVID-19 prevention, and were therefore not willing to continue working. Conversely, another respondent specifically reported that data collection could continue because collectors were equipped with PPE. One respondent noted that although routine data collection was continuing, her organization was facing challenges to adapt their processes for quality assessments, including annual audits of providers and client exit interviews.

Multiple respondents across settings did note that movement restrictions delayed or impeded reporting. However, many respondents across settings also reported innovative solutions for data reporting using technology, including shifting to electronic data reporting, introducing tablets for data collection and reporting, scanning data, and taking and sending pictures of registers using WhatsApp. One respondent noted that their organization supplied staff with communication credits and funds to purchase telephones and data to transmit data.

One respondent expressed her belief that her organization's investment in training staff on data collection, reporting, and use in programmatic decision-making was critical to the organization's adaptivity amid the COVID-19 pandemic. Conversely, several respondents in humanitarian settings reported that existing challenges in data collection and reporting, such as insecurity and weak systems, persisted or were exacerbated during COVID-19, highlighting the importance of existing structures and systems to absorb shocks.



Training

Diverse respondents across settings reported that clinical training and capacity building for providers were significantly impacted at the outset of the pandemic. Respondents reported that movement restrictions resulted in trainings being canceled, and social distancing requirements made it very difficult for learners to convene and receive appropriate instruction.

Respondents described different adaptations to continue trainings, including social distancing, condensing or consolidating trainings, holding a larger number of trainings with smaller groups of providers (although this had negative implications, both for the number of providers able to be trained and for cost), and holding trainings via Zoom or other platforms where feasible and appropriate.

In one example, an INGO respondent based at the headquarters level of an organization working across settings described a training in which all elements were conducted via Zoom, apart from the practical component—which was accomplished by having learners meet with the trainer to reach competency one at a time, with all parties using PPE. The respondent noted that while this approach was successful in terms of building capacity, it was highly time and resource intensive.

Moreover, one respondent observed that using technology to continue providing trainings could result in particularly limited access to trainings for community health workers, compared to facility-based providers.

Community sensitization

Many respondents across contexts stated that community sensitization and mobilization activities were severely disrupted by the onset of COVID-19, particularly the institution of movement restrictions and lockdowns—they were not able to deploy staff for outreach or convene community members in groups. One respondent also noted that many programs rely on waiting rooms to link services and share information about available services with clients—pathways that were disrupted by the reconfiguration of facilities to maintain social distancing.

However, respondents reported that demand creation activities gradually resumed as lockdowns and movement restrictions eased, albeit in smaller groups, and socially distanced—even using “town criers” with loudspeakers and megaphones. One INGO respondent working at the country level in humanitarian settings described this adaptation, saying, “So, these ‘town criers’ each had an individual megaphone ... [and they] remind [communities] that all the services are open, and that anyone who needs family planning services can go there, and that if [anyone] has taken [a contraceptive] and has a side effect that they [should not] hesitate to call the green number, and we will support them.” Respondents also noted that community health workers were included in trainings on infection prevention and control and provided with PPE.

Demand for services

In addition to the barriers posed by movement restrictions, respondents across settings nearly unanimously reported that communities were afraid to seek services due to the risk of COVID-19, or were deterred by messaging about the importance of isolating at home.

Several respondents working in humanitarian and development settings also reported decreases in demand due to communities’ fear and mistrust of health authorities and systems, including in

settings with a history of Ebola; myths and misinformation about COVID-19; and a lack of trust in health authorities to manage the pandemic. Notably, one respondent reported that uptake improved after stakeholders were able to establish a dedicated COVID-19 treatment center, ensuring that communities felt more comfortable visiting other facilities.

Respondents representing a number of settings also described communities being unable to leave their homes, or being turned back by authorities when attempting to reach facilities. One respondent reported that organizations conducted outreach to law enforcement agencies to ensure they were aware that services were available, and that people should be allowed to access them. Notably, he perceived that this posed a particular barrier for SRH services, especially contraception, compared to other health services.

Facility closures exacerbated the barriers posed by distance, and multiple respondents across settings described increases in transportation costs due to the pandemic. Accordingly, respondents in both humanitarian and development settings were particularly concerned about reaching marginalized and isolated or rural communities. One respondent from a national NGO referred to the economic impact of COVID-19 for refugees in their country, stating that many people had lost their jobs and could not afford to seek services. Several respondents reported that clients were not able to seek services, or were turned away from facilities, because they did not have or could not afford their own masks.

One INGO respondent stated that in one humanitarian setting, communities were deterred from seeking services because facilities were not consistently communicating about service availability, including the days and times that facilities were open during the pandemic.

Barriers for marginalized populations

Respondents were asked whether marginalized populations, including adolescents, persons with disabilities, people with diverse gender identities and sexual orientations, people living with HIV/AIDS, and people engaged in transactional sex, faced particular barriers or challenges to accessing contraceptive and SRH services. With the exception of adolescents and people living with HIV/AIDS, respondents across organizations and settings largely reported that they did not have concrete data or information on access to contraception among these specific populations, but supposed that barriers would be particularly onerous for marginalized communities.

One respondent from a national organization operating in a country with a large refugee population expressed that refugees faced heightened barriers, citing increased distance to services and higher transportation costs as being particularly challenging. She also linked these challenges to heightened barriers for persons with disabilities, and hypothesized that reductions in the size and scale of community sensitization activities could pose particular challenges for persons with disabilities, who may be more isolated.

Impact on adolescents

Respondents across organizations and settings spoke extensively about the impact of COVID-19 on adolescents' health and safety. Respondents were highly concerned about adolescents being out of school, increases in gender-based violence (GBV), including sexual exploitation and child, early, and forced marriages, and possible increases in adolescent pregnancy. One respondent reported that their organization prioritized condom distribution for adolescents and young people for protection against sexually transmitted infections (STIs), including HIV.



Respondents across settings discussed concerns that COVID-19 was poised to erode countries' progress in reducing adolescent pregnancy. Conversely, one INGO respondent working in humanitarian settings at the regional level reported that in one country, her organization reported an increase in adolescents presenting for contraceptive services.

Two respondents in humanitarian settings, including one at a ministry of health, said that barriers for adolescents during COVID-19 were exacerbated by the fact that adolescent-friendly services had not been extensively available in-country prior to the onset of the pandemic.

One respondent reflected that even amid the pandemic, supporting adolescents' access to SRH services and information, including contraception, was politicized. Another national NGO respondent cited inadequate sexuality education in the country prior to the pandemic, lamenting:

"We have left so many loose ends because of the policy environment. You know, you have all these stories about sexuality education in the country, and then ... religious institutions are saying it is not an appropriate use of education. But we have learned in the last six months with COVID, and looking at teen pregnancies, child marriages—it is definitely clear that programming for young people is very, very important. And that means that in terms of advocacy, we need to step up our efforts."

She continued, advocating for strengthening the linkages between information and services: "Information alone is not addressing the challenge. We must have interventions that link information and services. We have done the talking, and the girls are getting pregnant."

She concluded by emphasizing the importance of building support among parents and teachers for adolescents' access to SRH information and services, and delivering holistic services for adolescents that not only address their health, but also their socioeconomic and social well-being—particularly in the aftermath of COVID and the economic and social devastation it is driving.

Contraceptive service delivery adaptations amid the COVID-19 pandemic

Respondents were essentially unanimous in citing infection prevention measures as being instrumental in their ability to resume or continue service delivery safely. Commonly cited measures included handwashing and the use of hand sanitizer, the use of PPE for providers, including (depending on the respondent) masks, gloves, gowns, and face shields, and the use of PPE for clients—specifically, masks. Respondents also reported that facilities set up screening stations for clients prior to entry that included measures like taking their temperature, asking about possible exposure to COVID-19, and sharing information on COVID-19 testing and precautions when appropriate. Respondents also consistently reported adopting social distancing measures, like reconfiguring facilities to prevent congregating in reception areas and spacing out providers and clients.

Use of technology and telemedicine

Respondents were also essentially unanimous in reporting the use of technology to support the maintenance of operations and, depending on the organization, at least some elements of service

delivery. Respondents in both humanitarian and development settings described developing protocols to connect with clients via telephone and WhatsApp to schedule appointments, provide counseling, direct clients to obtain their methods, and conduct follow-up.

Some respondents, including in humanitarian settings, reported that their organizations established helplines or call centers to field inquiries on SRH and contraceptive services. One respondent described his organization's response in one humanitarian setting:

"So, in a span of two and a half weeks, [the organization] worked with the ministry of health and other partners ... and quickly mapped all continuing and free service-providing locations, [and] created a call center ... that they managed. And in two-and-a-half weeks, we seamlessly shifted from having crowds in our clinics to actually saying, 'Call the center and you go through your symptoms, tell us what your location is, and we'll tell you what's the easiest way to get [your method], whether it's someone home delivering it through a [community-based delivery mechanism] or referral to a private sector [facility].'"

Respondents described training providers to provide counseling and follow-up using technology, and supplying providers with communication credits and telephones to support these adaptations.

However, telemedicine requires time, resources, and baseline infrastructure. Some respondents in both development and humanitarian settings noted that it was not feasible for their organizations to implement telemedicine because they did not have the necessary resources, time, or infrastructure, in terms of electricity and/or connectivity. One national NGO respondent in a humanitarian setting noted that although they developed proposals to implement telemedicine, they were not awarded funding, and were therefore not able to do so. One INGO respondent working across settings reported that she observed that telemedicine was more available in development compared to humanitarian settings.

Respondents reflected that these adaptations could be taken forward immediately and maintained in the aftermath of the pandemic to improve access to services, including for adolescents and marginalized or isolated populations. One respondent, working on humanitarian programming at the headquarters level of an INGO working across settings, said, "There's such an opportunity there. We'll just make certain people's lives a lot easier, and decrease travel for women and providers, and everyone involved. That's not something novel. We've discussed [this] for a long time and that we wanted to take [telemedicine] forward. This is just the kickstart. There's opportunity now." Multiple respondents across settings indicated that their organization anticipated continuing and/or exploring the feasibility and benefits of digital interventions moving forward.

However, one INGO respondent working across humanitarian settings emphasized that the success of telemedicine and technological outreach for contraceptive service delivery depends on women and girls having access to cell phones and/or the internet—and in many settings, this is not the case.

Multi-month supplies

Many respondents across settings reported increasing the amount of short-acting contraceptives, including (depending on the respondent) oral contraceptive pills (OCPs), sub-cutaneous injectables (DMPA-SC, brand name Sayana Press) for self-injection, and condoms provided to clients to reduce the frequency of visits to facilities. Respondents representing a range of settings noted that COVID-19 guidelines issued by global health authorities and many governments promoted distribution of these methods to clients in multi-month supplies.



Task-shifting and sharing

Some respondents working in humanitarian and development settings reported task shifting and/or sharing to support the availability and accessibility of contraceptive services, including the authorization of community health workers to provide contraceptive methods, and shifting the provision of certain contraceptives to pharmacies or dispensaries.

One INGO respondent based at headquarters and working across settings expressed his belief that the pandemic has “primed” stakeholders for task sharing and shifting and “expanded conversations.” He stated, “It’s been more inclusive to say, ‘We can’t be doing this at our district hospitals because all [the] beds are taken by COVID. Therefore, it’s okay for it to be happening at the [primary healthcare] level.’ And so, it’s unfortunate, the motivations for why task-shifting happens, but I think it’s become a lot more visible.” He continued, “It’s also showed that change is possible. I think that’s impressive. I think we need to really recognize that, as we say, necessity is the mother of invention: not having enough opportunities to access services deregulated services in a way that we found could be potentially effective.”

Community-based contraceptive information and service delivery and distribution

Respondents described a range of experiences with community-based service delivery and distribution of contraceptive supplies during COVID-19. As previously noted, some respondents reported that their community-based distribution activities were suspended or significantly reduced due to concerns that community health workers could spread COVID-19 between households and communities. Other respondents reported that community-based distribution resumed or continued, with the provision of PPE and social distancing adaptations.

However, community-based distribution was cited by a number of respondents across organizations and settings as an effective tool to reach communities with information about available services and the importance of continuing to seek SRH services, and to deliver contraceptive services and commodities, ranging from condoms to a full selection of short-acting methods.

One respondent from a national NGO in a humanitarian setting described his organization’s efforts to secure funding to maintain and expand community-based distribution of contraceptives through community outreach midwives. He reported that with the funding they received, they were able to recruit 50 community outreach midwives and procure contraceptive commodities and PPE, and said: “If people are not coming to the clinics, we have to reach them in their home. Believe me—when we were...reaching them in their homes, they were saying that [they were] out of contraceptives. We were thinking we had to get them these services.”

In addition to service delivery, respondents across organizations and settings described a multitude of innovations to reach communities with information about contraception. Notably, respondents consistently reported that these messages were tailored for COVID-19, and were intended to notify communities that services were available and that it was safe and important to continuing seeking SRH services, including contraception and deliveries. One respondent from a national NGO explained:

“So, for example, if we are developing a spot message for radio, it would say, “Even as you stay home because of COVID-19, please come to the health facility for your family planning appointment. Please reach out to [our organization] for information and services.” So, looking at the COVID message, and bringing in the sexual and

reproductive health aspect. One, it was looking at effective use of resources—you do not want to have vertical messages [...] And we also wanted our audience to appreciate that even within the COVID situation, they still appreciate the sexual and reproductive health needs, the family planning needs, the needs of adolescents ... to bring this kind of hope to the community. Even when you are locked down, the facilities are open for you to access the services.”

Multiple respondents across settings discussed disseminating information on the radio, on television, on social media, and through community leaders. One INGO respondent working in humanitarian settings provided a notable example of a country program with adolescent health committees affiliated with different facilities—groups of adolescents dedicated to increasing awareness of and demand for contraceptive services among their peers. She said that these committees were extremely adaptable, and pivoted immediately to social media platforms to continue their work.

However, another respondent expressed that adolescents faced particular challenges accessing information because they were not able to participate in their normal group activities, including attending church and school, and reported a perception that adolescents in their context had been particularly impacted by unemployment. One Ministry of Health respondent also reported that adolescents in her country had been particularly susceptible to misinformation about COVID-19.

While some respondents ceased or were prohibited from deploying community health workers, several respondents across settings also reported engaging community health workers to disseminate information about contraceptive services during COVID-19—again, reflecting the extent to which disruptions and adaptations were highly context dependent. One INGO respondent, based at the headquarters level and working on a project in a number of development settings, reflected that although “door-to-door” sensitization activities were more time intensive, this shift had proved advantageous for reaching adolescents and marginalized communities. She said:

“One of the interesting effects of [door-to-door sensitization], is that there’s been, at least a maintenance of or if not an increase in, the number of youth that are accessing services. And we’re just starting to have this sort of the hypothesis of perhaps ... [outreach activities] are reaching populations that they haven’t actually been reaching in their previous outreach methods. So that’s one of the positives...like married adolescents that may normally not be able to go outside that have perhaps been getting access to information.”

For more information on adolescents’ access to contraceptive information and services during COVID-19, see section “Impact on adolescents” on page 8.

Self-administration of DMPA-SC

As with community-based distribution, respondents described a range of experiences with supporting women and girls to self-administer DMPA-SC as an adaptation to support the availability and accessibility of contraception during COVID-19.

A number of respondents representing both humanitarian and development settings noted that although self-administration of DMPA-SC was authorized in their country or supported by their organization prior to the onset of the pandemic, greater emphasis was placed on self-administration as part of COVID-19 response, including in community sensitization activities and training providers to support women and girls to self-inject. Two respondents cited the Democratic Republic of



Congo as a specific example of a country with humanitarian crises that accelerated approval of self-injection in response to COVID-19, and respondents across settings expressed that COVID-19 had significantly increased interest in self-injection among stakeholders. However, when queried, some respondents reported that they had not observed increases in prioritization or promotion of self-administration of DMPA-SC.

One respondent from an INGO reported providing technical support to ministries of health to ensure self-administration was widely available, including in humanitarian settings where women and girls might face particular barriers to services; another respondent from the same organization noted that the inclusion of self-injection in WHO guidance on ensuring continuity of services during COVID-19 was an effective advocacy tool with governments.

One respondent based at the headquarters level of an INGO working across settings reported that country colleagues had reported that amid the COVID-19 pandemic, implementing partners were being informally authorized to pilot innovative or previously unapproved approaches to service delivery, including telemedicine and self-injection. He emphasized the importance of stakeholders seizing this moment to ensure these advances were formalized and institutionalized. Several respondents expressed the perception that the pandemic had resulted in governments and stakeholders being more open to diverse mechanisms for service delivery.

Integrated service delivery

Multiple respondents representing humanitarian and development settings discussed the importance of integrating the delivery of contraceptive and SRH information and services with COVID-19 messaging and other priority health services to maximize resources and minimize communities' contact with the health system. Respondents discussed specific examples of coordinating primary health care activities, including immunizations, with contraceptive service delivery.

Factors affecting contraceptive access and availability amid the COVID-19 pandemic

Differences in disruptions and adaptations between humanitarian, fragile, and development settings

In conducting these interviews, we sought to learn more about similarities and differences in the impact of COVID-19 on contraceptive and SRH services across humanitarian and development settings, including disruptions and adaptations.

Respondents consistently described similar disruptions and adaptations, or expressed that the nature of disruptions and adaptations were highly similar across development and humanitarian settings—with disruptions including movement restrictions, lockdowns, and decreased demand due to fear of seeking services, and adaptations such as telemedicine and community-based distribution. The specific disruptions and adaptations that occurred appear to be highly specific to the country or setting a program was operating in, including restrictions and guidelines.

Several respondents from humanitarian settings expressed that existing insecurity compounded the effects of COVID-19 on contraceptive and SRH service delivery, and complicated response efforts. This manifested in greater difficulties reaching affected and displaced population amid the COVID-19 pandemic, and further deterring people from seeking services.

Multiple respondents—working in both humanitarian and development settings—expressed that from their perspective, development settings were better resourced and able to absorb the shock of COVID-19, and that it was more challenging to adapt and maintain services and prevent the spread of COVID-19 in humanitarian settings, citing weaker health systems, lack of access to water and sanitation facilities, fewer resources, and limited access to technology. In one notable example, a respondent based at the headquarters level of an INGO working across settings discussed the particular challenges faced by one program in a humanitarian setting due to the large number of expatriate staff on the ground—with the onset of COVID-19, many people were evacuated, which depleted the support networks for teams and staff providing services.

However, a significant number of respondents—also working in both humanitarian and development settings—felt that humanitarian actors, and/or programs in humanitarian settings, were more responsive and agile in responding to COVID-19 and adapting contraceptive and SRH service delivery. Some respondents felt these actors and settings were better prepared, with relevant policies and procedures in place for emergencies; had stronger coordination mechanisms and were able to leverage existing relationships with partners, including governments; and were more responsive to shocks and better able to move quickly and prioritize service delivery.

Preparedness for sexual and reproductive health

Respondents were asked a series of questions about preparedness for SRH, including organizational preparedness; the broader state of preparedness in the settings where they operated, including the existence and strength of government preparedness plans; and preparedness actions that were taken specifically to address COVID-19.

Respondents were first asked about actions by authorities to prepare for the arrival of COVID-19 in their country or setting, and if these actions addressed continuity of SRH and contraceptive services. Some respondents in humanitarian and in development settings reported that upon the onset of the pandemic at the global level, governments undertook preparations and instituted measures to slow and control the spread of COVID-19 upon its arrival in country—noting that these measures did not specifically address continuity of contraceptive and SRH services—while a limited number of respondents expressed that authorities were slow to respond and did not take adequate measures, despite the clear evidence emerging from hard-hit countries that it was critical to act. However, respondents also noted that in some cases, extremely strict restrictions were instituted prior to the arrival of COVID-19 cases in country—restrictions that severely disrupted the provision of essential health services, including SRH and contraceptive services.

One INGO respondent perceived that it took a period of days or weeks following the institution of pandemic control measures before governments turned their attention in earnest to the continuity of essential health services; she believed that in contexts where she worked, it was the issuance of WHO guidelines on the continuity of SRH services that spurred governments to act. For more information on governments' and stakeholders' prioritization of contraceptive and SRH services amid the COVID-19 pandemic preparedness and response, see section "Prioritization of contraceptive and SRH services during COVID-19 response" on page 16.



As for preparedness prior to the onset of the pandemic, respondents working in humanitarian and development settings largely reported that governments did not have emergency preparedness plans for health in place, or were not adequately prepared to respond at the onset of the pandemic; some respondents indicated that they were not sure whether governments in the settings where they worked had preparedness plans. Some respondents expressed that existing government preparedness plans did not include or adequately prioritize SRH, and some respondents acknowledged that SRH preparedness plans were not necessarily operationalized. One respondent from a national NGO in a humanitarian setting said that his organization had worked with the emergency preparedness and response department at the national health ministry in 2018 to include the MISP for SRH in preparedness and response plans, but “The plan was there, but, during COVID-19, it was not effective. It was of no use, I would say. The government was prioritizing something else. They had limited resources.”

When queried as to whether their organizations had preparedness plans in place prior to the onset of the pandemic that were leveraged in COVID-19 response, diverse respondents in both development and humanitarian settings largely reported this to be a significant gap. However, several respondents—primarily in humanitarian settings—did report that their organization had preparedness plans in place, or cited activities taken prior to the onset of COVID-19 as supporting their COVID-19 response, including training providers, staff, and other stakeholders on the MISP for SRH and supply chain strengthening to ensure there was stock on hand when the emergency erupted.

However, even respondents who cited organizational or government preparedness plans acknowledged that they did not anticipate a global pandemic—their plans were largely designed to address conflict or natural disasters, and were not reflective of the particularities of COVID-19 response, including movement restrictions and the need to procure PPE. Many respondents reflected on the unprecedented nature of COVID-19, although several respondents, including a ministry of health respondent, in contexts impacted by Ebola outbreaks indicated that that this experience primed stakeholders to respond to COVID-19 and implement stringent infection prevention and control measures.

When queried as to why they believed their organization did not have preparedness plans, several development INGO respondents expressed the perception that development stakeholders still largely do not consider preparedness to be part of their remit, and may not be aware of or engaged with preparedness activities or mechanisms in the settings where they work.

Critically, although the majority of respondents reported ineffective or a lack of prior preparedness, respondents were essentially unanimous in perceiving this to be a gap. Multiple respondents reflected on how preparedness could have resulted in better protection and preservation of essential health services, including contraceptive services, had it been in place prior to the COVID-19 pandemic. Respondents identified the gaps in and value of preparedness as a key lesson learned, expressed that their organization’s experience operating amid the pandemic had reinforced the importance of strengthening their investment in preparedness moving forward.

Prioritization of contraceptive and SRH services during COVID-19 response

Perceptions of the level of prioritization of contraceptive and SRH services among governments and stakeholders varied across respondents. Numerous respondents across settings reported that although authorities did not consider contraceptive and SRH services when instituting initial restrictions, many governments did include contraceptive and SRH services as essential services in

the development of longer-term COVID-19 response guidelines and plans, or that governments were receptive to advocacy that contraceptive and SRH services be prioritized. Others, also across settings, were adamant that governments failed to prioritize SRH and contraception.

Advocacy by respondents emphasized the long-term risks of women and girls being unable to access contraceptive services, including increases in unintended pregnancies, unsafe abortion, and maternal mortality and morbidity. Some respondents reported that lessons learned from the impact of Ebola outbreaks on maternal and child mortality and morbidity were leveraged to ensure that SRH services remained available amid the COVID-19 pandemic. Notably, a number of respondents clarified that even where governments recognized the importance of SRH, contraception specifically was not adequately prioritized, and called for continued advocacy to ensure that all stakeholders recognize that contraception is a lifesaving intervention.

Several respondents also reported that high levels of global and national attention to increases in GBV, particularly intimate partner violence, during COVID-19 provided an opportunity to advocate for increased prioritization of other SRH services, including contraception. Per one respondent, “[Y]ou cannot talk about GBV without talking about SRH. ... I think it’s the opportunity to say, ‘Okay, this is a package, and you cannot do one without doing the other.’”

Several respondents representing humanitarian and development settings emphasized the importance of leveraging existing relationships with authorities to ensure that SRH services were included in preparedness and response plans, and that SRH stakeholders were at the table to inform these decision-making processes. One respondent based at the headquarters level of a humanitarian INGO provided a striking example from a country program:

“[R]ight before COVID-19 our [country] team ... [was] having a series of meetings with their government counterparts on handing over management of facilities to their government counterparts, on supporting and strengthening systems for contraception in the project communities. And I think because right before COVID-19, there were such strong relationships that were built, you know, when COVID-19 hit, the government then came to [our organization] and said that they wanted our help to implement the MISP, and ensure contraceptive service continuity. ... I think it definitely demonstrates how important that type of advocacy and relationship building in the preparedness stage [is, and how it] can reap rewards for response. ... It was because we were having those conversations [that] the government came to us and said, ‘We want to prioritize this. Can you help us do this?’”

However, respondents also acknowledged gaps between theory and practice—that inclusion of contraceptive and SRH services in guidelines and plans did not necessarily guarantee available and accessible services for girls and women. Respondents reported cases of governments in humanitarian and development settings failing to allocate funding to contraception and SRH activities, or shifting funding away from contraception and SRH activities as a result of COVID-19. For more information on the impact of COVID-19 on funding for contraceptive and SRH services, see “Funding” on page 20.

Using the MISP for SRH to guide service delivery prioritization

Respondents were asked if their organization was using the MISP for SRH, or if they had observed the use of the MISP for SRH, to prioritize the delivery of SRH services during COVID-19 response. Many respondents—largely those working in humanitarian settings—reported that their organization and/or other stakeholders did use the MISP to inform SRH service delivery during COVID-19. Two



respondents from one INGO that works in both humanitarian and development settings noted that their organization used the MISP for SRH extensively to inform the development of resources for staff on prioritizing and delivering SRH services. However, one INGO respondent, based at the headquarters level and working in humanitarian settings, reported efforts to use the MISP for SRH to inform the development of COVID-19 preparedness and response plans received pushback due to the politicization of SRH services.

One respondent based at the headquarters level of an INGO working across settings also reported that his organization's decision-making about how to prioritize SRH services was complicated by challenges in determining whether or not COVID-19 constituted a humanitarian emergency—however, he said, "Once we'd recognized that, yes, this is an emergency—this is not business as usual, this is not daily life, so we need to really work on a very different timescale, the MISP was the first document that we went to. And we structured our prioritization based on MISP."

Notably, he felt that the MISP for SRH played a critical role in what he perceived to be better prioritization of SRH in humanitarian settings, compared to development settings, from the outset of the COVID-19 pandemic: "So, the reason why prioritization was better in humanitarian settings, in my opinion, is that sexual and reproductive health is part of the conversation. So, you have a structure ... [the] health cluster, [and] within [the] health cluster, you have [the] MISP. So, you have the tools ... you're sort of aligned, the actors, on what are the things you need to look at."

However, he noted that while the MISP is tremendously useful in these initial prioritization activities, it is not intended to be used for extended periods—in fact, it includes the objective of transitioning to comprehensive SRH services as soon as possible. Accordingly, he emphasized the importance of accounting for the duration of the pandemic in planning activities, and reported that with this in mind, his organization sought to ensure that services beyond those included in the MISP for HIV and STIs continued, as well as cervical cancer services.

Using other guidance on adapting services during COVID-19

Multiple respondents reported experiencing challenges due to the large volume of guidance documents on service delivery adaptations that were produced in response to COVID-19, particularly in the early weeks of the pandemic—not only by governments and global health authorities, but also by organizations and donors. Respondents reported being "inundated" and struggling to read and process the "deluge" of guidance documents they were receiving, and expressed concerns that many of these documents were duplicative.

However, two INGO respondents cited the WHO operational guidance for maintaining essential services as being highly useful to inform service delivery; one respondent expressed that the inclusion of contraceptive and SRH services as essential services in this guidance supported his organization to make the case for the continuation of SRH and contraceptive service delivery in some settings.

Respondents at all levels expressed concern that the high volume of guidance from multiple sources was particularly taxing to the staff on the ground who were actually responsible for implementing the adaptations, and already confronting the tremendous strain of working on the front line to deliver services amid a pandemic. In this vein, respondents also noted that many guidelines did not provide actionable information to operationalize the recommendations.

For example, one INGO respondent at the headquarters level reported receiving questions from staff at the country level in response to a recommendation to make certain contraceptive products available over the counter that was included in multiple documents. However, she noted that in

many countries, to do so would require undertaking an extensive process involving multiple national health and drug authorities—rendering the recommendation essentially useless in the short term when staff were working as quickly as possible to ensure services remained available and accessible.

Respondents said that effective guidance should reflect the highly contextual nature of the pandemic and its impacts. One respondent based at the headquarters level of an INGO working across settings said that they aimed for “global alignment” while allowing for “local decision making and leadership”:

“[The organization] was never prescriptive in its task force to say, ‘This is what you need to do.’ We were very clear in setting the frameworks, and within that, we gave them enough opportunity around how you want to pick and choose for your local context. And this goes back to something that I strongly believe in about standards versus standardization.”

Notably, multiple INGO respondents at the headquarters level—from both humanitarian and development organizations—emphasized the importance of recognizing and prioritizing the expertise of frontline staff and providers, given the highly contextual nature of the pandemic and its impacts on contraceptive and SRH service delivery environments.

Coordination

Respondents’ experience with coordination mechanisms and efficacy varied. Respondents across humanitarian and development settings largely reported existing coordination mechanisms, including clusters in humanitarian settings and technical working groups, continued to meet—although some respondents in both humanitarian and development settings described challenges and delays in moving meetings to virtual platforms, citing lack of capacity with and uneven access to technology and connectivity across partners. Coordination mechanisms also faced challenges due to the demands created by responding to the pandemic: in one case, a national NGO respondent in a humanitarian setting reported that existing SRH coordination mechanisms were disrupted for weeks because they were not able to connect with their colleagues in the government.

Some respondents did report that new mechanisms for COVID-19 preparedness and response were established. One INGO respondent working at the regional level within Eastern and Southern Africa reported that many countries within her scope of work established national COVID-19 task forces. She also reported that existing SRH coordination mechanisms, including clusters, were merged with or upgraded to task forces. In another region, an INGO respondent reported that a regional COVID-19 coordination mechanism was established, but it did not include all health actors, including SRH stakeholders.

Respondents across humanitarian and development settings reported that coordination played a number of functions, including advocacy to prioritize contraception and SRH, and in some cases, the development of guidelines; ensuring the availability of supplies and commodities, including PPE; service delivery and coverage, including for GBV; and community outreach. A respondent with a national NGO provided one example of coordination leading to innovative solutions, in which organizations working in different regions were able to maximize their outreach to communities after coordination helped them to identify gaps around sensitization. The organizations worked together to establish radio stations and develop consistent messaging about contraceptive and SRH services, and each organization took responsibility for having the messages translated into the appropriate local languages, recorded, and distributed in its area.



However, respondents also described challenges with coordination for SRH, including contraceptive services. One INGO respondent working across settings at the regional level reported that she did not observe stakeholders coordinating service delivery, and another INGO respondent, based at the headquarters level and working in humanitarian settings, expressed frustration with “lip service coordination” in one humanitarian setting in which stakeholders were reportedly working together, but did not fully operationalize coordination. One national NGO respondent reported that her organization was included in COVID-19 coordination, which was positive, but that they lacked the resources to follow through with implementing planned activities. Another INGO respondent working at the country level described challenges with information flow from the national to district level to inform response, and one ministry of health respondent reported that in some cases, implementing partners worked in parallel to governments for COVID-19 response.

Respondents stated that the existence of strong coordination mechanisms prior to the onset of COVID-19 facilitated effective response. One national NGO respondent from a country experiencing a humanitarian emergency said that the SRH coordination mechanism in her setting was effective because “We all knew each other. We all know about each other’s work. This is why it’s this strong group in my view—we’ve been working together and coordinating together for a long time. It’s not just suddenly [that] it was created for COVID—we were working together before because we’re all facing the refugee situation.” Stakeholders could leverage existing relationships to respond quickly.

INGO respondents across humanitarian and development settings also discussed the importance of international coordination, particularly given the disruptions to transportation for supplies and commodities; one respondent reported that they were able to deliver SRH commodities to Syria and Yemen using World Food Program flights. Respondents noted that stakeholders coordinated at the international level to support partners on the ground to obtain commodities and supplies, and reported that some of this coordination was informal—once again underscoring the importance of existing relationships.

As previously mentioned, one INGO respondent working across humanitarian and development settings felt that humanitarian stakeholders and settings held a comparative advantage in this respect, given that coordination is emphasized and codified as standard practice in humanitarian response.

One respondent in a development setting felt that COVID-19 had improved coordination in his setting, “unifying” partners and facilitating more regular meetings, flow of information, and coordinated service delivery. Another development INGO respondent indicated that experiences over the course of COVID-19 had underscored the value of coordination with humanitarian stakeholders in the settings where her organization works. She noted that concurrently to planning a training for multiple partners at the country level, she had been communicating with a colleague at a humanitarian INGO about a separate matter—but as a result of that unrelated conversation, she was able to include that organization’s country team in the training. She reflected, “[I]t seems so apparent that yes, of course, we should be reaching out to humanitarian actors about opportunities like that. But I think those relationships don’t necessarily exist across the nexus at the country level.”

Finally, a number of respondents discussed the advantages of multi-sectoral coordination that had emerged over the course of the pandemic. One respondent said, “I was very amazed to see, you know, when you’re talking about family planning or reproductive health, you’re beginning to see other sectors also coming in, child health ... nutrition. ... And beyond that, when you went to the country level, the other sectors like education, agriculture, [were] also beginning to actually have a conversation with the health sector ... so that then you can see how then you synergize across the sectors.”

Funding

Respondents were asked a series of questions about the impact of COVID-19 on the funding environment for contraception and SRH in humanitarian and development settings. Respondents across settings largely spoke positively about their donors' response to COVID-19, including by allowing flexibility to pivot and adapt programming. Respondents noted that they were able to reallocate funding internally—away from travel, for example—to address costs associated with COVID-19.

The majority of respondents reported that they had not had to reallocate existing organizational funding away from SRH to COVID-19 activities. However, respondents reported that COVID-19 significantly increased operating costs. Multiple respondents across organizations and settings reported seeking, and in some cases receiving, new or additional funding to support the procurement of PPE and program adaptations. Although respondents acknowledged that many donors were focused on COVID-19 response, several respondents reported conducting successful outreach to donors to secure additional funding to ensure continuity of SRH services, or even being approached by current donors seeking to increase support to SRH services amid the COVID-19 pandemic. A limited number of development respondents reported moving to tap new, humanitarian funding streams—for example, the Central Emergency Response Fund (CERF)—but this was not universal across respondents.

However, a small number of respondents—representing both national NGOs and INGOs—also reported that donors were not able to follow through on funding planned projects as a result of COVID-19, either because funding was shifted to COVID-19 activities, or due to financial challenges facing the donor. Notably, one respondent based at the headquarters level of an INGO working across settings stated his belief that donors could have improved response by improving coordination among themselves.

Moreover, as previously mentioned, some respondents reported that governments had reallocated funding away from SRH, although other respondents reported that their efforts to ensure that governments maintained funding for SRH were successful.

Respondents across organizations and settings described conducting advocacy to donors, and many reported that donors had indicated their intention to maintain their commitment to SRH, while acknowledging that they were still not sure exactly what that would look like. When asked about the longer-term impacts they saw or anticipated in the funding environments, respondents described heightened uncertainty. Many noted that the economic impacts of COVID-19 will also affect donors, and expressed concerns about the availability of funding for an extended period.

Tracking what works now and in future emergencies

In concluding the KIIs, respondents were asked to reflect on lessons learned and key takeaways from their experience supporting or delivering contraceptive services amid the COVID-19 pandemic.

Humanitarian and development respondents expressed that the onset and impact of COVID-19 has underscored both the importance of and gaps in preparedness for SRH, and the role preparedness plays in ensuring that health systems are adaptive. Respondents also emphasized the importance of



development actors recognizing they have a role to play in preparedness, and discussed the changing natures of crises, the growing fragility and vulnerability to hazards across contexts—including those settings still considered to be “development.” One development respondent reflected:

“[Th]is is not the first pandemic, and this is not going to be the last one. In five or ten years, there’s going to be another pandemic. If we don’t have some things very global like this one, there’s going to be crises even in places where we think, ‘Oh, this is a development setting.’ Because if you look at many political regimes ... crises are coming. There are crises waiting for us in the next five years. Just because of the political turmoil. And this is something that those organizations that define themselves as development actors need to internalize.”

More broadly, respondents perceived that COVID-19—a global emergency—has spotlighted the challenges posed by siloes between humanitarian and development stakeholders. One respondent called for “moving away from a discourse that talks about humanitarian versus development,” and instead focusing on building resilient, adaptive health systems capable of absorbing and managing shocks, including epidemics and pandemics. Respondents discussed the importance of building health systems strengthening activities into program design, implementation, and evaluation, and investing in local stakeholders to ensure contraceptive and SRH programming is resilient and sustainable in the long term. A humanitarian INGO respondent stated that from her perspective, “Where service continuity is thriving are places where, pre-COVID-19, there were good initial family planning investments, really highly specialized and trained staff, family planning champions—having those foundational pieces in place.”

Respondents also noted that the particular demands of responding to COVID-19 have demonstrated that it is possible to accomplish far more virtually than was previously thought, and that maintaining this way of working has the potential to shift resources closer to the field, and to increase the resources available for priority activities, including systems strengthening and investing in local actors. However, one respondent based at the headquarters level of an INGO working across humanitarian and development settings noted that despite the discussion surrounding localization amid the COVID-19 pandemic, they have not observed significant corresponding shifts in the flow of funding—and stated that for localization to take place in a meaningful way will require investment and prioritization on the part of donors.

Several respondents also discussed conducting research and data collection to investigate and document the impact of COVID-19, and their organization’s response. Respondents emphasized the importance of documenting the impact of COVID-19 and what worked—or did not—to ensure that essential services continued to be accessible and available to inform preparedness and response in the future. One INGO respondent described her organization’s approach to data collection on adaptations as “story mapping,” noting that this type of data visualization supported users to explore across sectors and types of adaptations. She reported that developing the map over the course of months provided the organization with “tremendous” information, but was also a “heavy lift”—reflecting the investment required to ensure data on impact, adaptations, and lessons learned is not lost. Notably, another respondent from an INGO perceived that her organization was struggling to streamline collection of data on COVID-19 impacts and adaptations across countries, sectors, and programs, and expressed concerns that the system had redundancies, and was inefficient for staff.

Another respondent said, “I think the global community is a lot more systematic in documenting [the impact of COVID-19] and getting data out there. In the past, when you’ve had [the] Ebola crisis come out, there’s always been talk only about maternal deaths. We [had] not seen the same kind of

data or the rigor applied to creating a body of evidence to say how we can access things, how we can [better] ensure access to SRH services. And I think that is a positive.”

Notably, several respondents also reflected on the importance of capturing the experiences and perspectives of clients and communities. One respondent described conducting focus group discussions with providers, community health workers, and community members, while another respondent expressed that in documenting adaptations, she felt that her organization was missing “the voices of people who actually access services in these different ways.” She said: “[T]hat’s going to be a critical, critically important, part of our own evaluation—to say which of these [adaptations] should actually be integrated into programs going forward, because they really do work or did work, and helped our clients meet their needs in a way that they felt was client-centered, and gave them a positive experience.”

Although the COVID-19 pandemic has posed extensive and often unprecedented challenges across sectors of humanitarian response—including SRH—it has also provided a unique opportunity to make the case for the value and feasibility of implementing evidence-based policies and mechanisms for contraceptive service delivery, including task-shifting and sharing, community-health service delivery, integrating contraceptive service delivery with other essential health services, including immunizations, and use of media and digital technology—all of which are in line with High Impact Practices for Family Planning (HIPs)⁷ and WHO guidelines for self-care for SRH⁸ and task-shifting and sharing for maternal and newborn health, including contraceptive services⁹ in humanitarian settings. Stakeholders, including donors and implementing partners, must continue to invest in documenting and sustaining innovations that can expand the accessibility and availability of contraception for crisis-affected girls, women, boys, and men in all their diversity.

Discussion

The COVID-19 pandemic acutely impacted the availability and accessibility of contraceptive services across humanitarian, fragile, and development settings. Respondents were essentially unanimous in reporting that contraceptive service delivery was disrupted by restrictions instituted at the outset of the pandemic, including lockdowns, facility closures, and movement restrictions.

- 7 Family Planning High Impact Practices, “High Impact Practices in Family Planning,” updated October 2020, www.fphighimpactpractices.org/high-impact-practices-in-family-planning-list; Family Planning High Impact Practices, “Drug Shops and Pharmacies: Sources for family planning commodities and information,” www.fphighimpactpractices.org/briefs/drug-shops-and-pharmacies; Family Planning High Impact Practices, “Community Health Workers: Bringing family planning services to where people live and work,” www.fphighimpactpractices.org/briefs/community-health-workers; Family Planning High Impact Practices, “Family Planning and Immunization Integration: Reaching postpartum women with family planning services,” www.fphighimpactpractices.org/briefs/family-planning-and-immunization-integration; Family Planning High Impact Practices, “Digital Health for Social and Behavior Change: New technologies, new ways to reach people,” www.fphighimpactpractices.org/briefs/digital-health-sbc; Family Planning High Impact Practices, “Digital Health for Systems: Strengthening Family Planning Systems Through Time and Resource Efficiencies,” www.fphighimpactpractices.org/briefs/digital-health-systems.
- 8 World Health Organization, *WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights*, (2019), www.who.int/reproductivehealth/publications/self-care-interventions/en.
- 9 World Health Organization, *WHO recommendations: Optimizing health worker roles for maternal and newborn health through task shifting*, (2012), <https://optimizemnh.org/>; World Health Organization, *Task sharing to improve access to Family Planning/Contraception*, (2017), <https://apps.who.int/iris/bitstream/handle/10665/259633/WHO-RHR-17.20-eng.pdf?sequence=1>.



Across settings, these restrictions impacted contraceptive services in a number of ways. In addition to facilities in some settings being forced to close, respondents across organizations and settings reported that restrictions impeded providers' ability to reach facilities, disrupted supply chains for contraceptive commodities, and forced the cessation of some community-based service delivery and sensitization activities. Respondents also reported that restrictions disrupted other activities essential for sustainable, responsive contraceptive service delivery, including data collection and reporting, provider supervision, and training.

Moreover, these restrictions hindered communities from being able to reach service delivery points, and many respondents perceived or were concerned that barriers were particularly onerous for adolescents, rural or isolated communities, and for members of marginalized populations, including persons with disabilities and refugees. Respondents across a range of settings noted that a lack of access to contraception was compounded by other challenges facing adolescents amid the pandemic, including being out of school and isolated from their peers, and increases in GBV, including child, early, and forced marriage. Respondents felt that adolescents were and will be vulnerable to the pandemic's economic fallout, and emphasized that effective SRH programming for adolescents should be tailored to address their unique needs and preferences, and holistic, linked to comprehensive information, services, and programming that address protection, education, and livelihoods.

Many respondents representing diverse organizations and settings expressed that contraceptive, and SRH services more broadly, were initially subject to these restrictions in part because government authorities did not perceive contraceptive and SRH services to be essential or lifesaving, and reported conducting advocacy with governments to ensure that contraceptive service delivery resumed and was adequately prioritized. Respondents largely reported that governments were receptive to this advocacy, but multiple respondents reported governments shifting funding away from contraception. Furthermore, multiple respondents noted that contraceptive services continued to be deprioritized compared to other elements of SRH, underscoring the critical importance of ongoing advocacy to raise awareness across authorities and stakeholders that contraception is lifesaving, and a standard component of humanitarian health response.

Respondents cited a number of advocacy strategies and tools as being effective, including drawing on the WHO guidelines on continuity of essential services; citing the potential long-term impact on maternal morbidity and mortality, including lessons learned in the aftermath of Ebola; and linking the provision of contraceptive services to protection and GBV response. Moreover, several respondents, primarily representing humanitarian settings, reported using the MISP for SRH to inform decision-making about SRH service delivery, including contraceptive services, amid the pandemic.

Respondents' organizations implemented numerous innovations and adaptations to ensure continuity of contraceptive and SRH services, including distributing short-acting methods in multi-month supplies; providing telemedicine and using technology to provide counseling, direct clients to obtain their methods, and conduct follow-up; task-shifting and sharing, including community-based service delivery and sensitization; promoting self-administration of DMPA-SC where feasible; and integrating contraceptive service delivery with the provision of other essential health services. Many respondents also reported using technology to adapt or maintain data collection and reporting, and provide training, supervision, and psychosocial support to providers.

Critically, multiple respondents from across organizations and settings reported providers falling ill, and in some cases dying, due to COVID-19—underscoring the risks that frontline responders face when an emergency strikes, and the disproportionate burden they assume. It is essential that

humanitarian actors recognize the importance of providing robust support—not only compensation and organizational infrastructure, but also psychosocial support.

Even in resource-poor and highly restrictive settings, respondents' organizations were able to innovate and rapidly adapt to reach women and girls with contraceptive innovations and services, demonstrating tremendous ingenuity and resourcefulness. However, respondents representing organizations in both humanitarian and development settings reported difficulties implementing some technology-based adaptations because they did not have the necessary resources, time, or electric and connectivity infrastructure. Although telemedicine and technology-based programming can effectively reach many women, girls, boys, and men with SRH information and services, stakeholders—ranging from donors, to governments, to implementing partners—must ensure that they maintain service delivery mechanisms that can reach all populations, even those without access to technology and connectivity.

Moreover, one INGO respondent working across humanitarian and development settings perceived that at the outset of the pandemic, initial emphases on telemedicine negatively impacted the provision of LARCs, and emphasized the importance of ensuring the full mix of methods was made available through multiple service delivery mechanisms. More broadly, several respondents reported that the provision of LARCs was more negatively impacted by COVID-19 compared to short-acting methods. Good quality contraceptive service delivery requires the availability of a range of methods to ensure that women and girls can select the method that works best for them—including LARCs. Over the course of the COVID-19 pandemic and in future humanitarian SRH responses, it is essential that governments and implementing partners have the supplies, trained providers, and contingency plans needed to provide LARCs.

The nature of disruptions and adaptations to contraceptive service delivery amid COVID-19 discussed by respondents was largely consistent across humanitarian and development settings and different types of organizations, while the extent of the disruptions and the specific adaptations appeared to be strongly influenced by the specific context in which the program was operating, particularly the parameters of the restrictions and guidance implemented in response to COVID-19. Again, this underscores the importance of conducting advocacy to ensure that governments and key stakeholders understand contraceptive services are essential, and must be maintained in designing and executing every crisis response.

Beyond disruptions and adaptations to service delivery, respondents discussed a range of factors influencing the availability of contraception amid the COVID-19 pandemic, including coordination with governments and partners, prioritization of contraceptive services in COVID-19 guidance and response plans, funding, and emergency preparedness for SRH— or, in many cases, a lack of emergency preparedness for SRH.

Some respondents in humanitarian and development settings reported that preparedness activities undertaken prior to the pandemic—even activities that were not specific to epidemics and pandemics—had facilitated their organization's response to COVID-19. These activities included training on the MISP for SRH, and supply chain strengthening. As previously noted, several respondents reported using the MISP for SRH to inform decision-making about SRH service delivery, including contraceptive services, amid the pandemic. One respondent expressed that the MISP for SRH contributed to stronger prioritization of contraception in humanitarian settings, compared to development settings, because stakeholders were aware that SRH services should be included as an essential pillar for an emergency health response, and were prepared to use the MISP for SRH in their decision-making. It is essential that all stakeholders implementing or supporting the delivery of



contraceptive services, including governments and development actors, are aware of and familiar with the MISPP for SRH, and are prepared to implement it in the event of an emergency.

However, the majority of respondents across settings reported that governments did not have or had not executed preparedness plans for SRH prior to the onset of the pandemic, or did not adequately prioritize contraception and SRH in preparedness plans for health. Respondents also acknowledged that existing preparedness plans for health did not address the possibility of a global pandemic. Similarly, respondents across types of organizations and settings largely indicated that their organization did not have preparedness plans or conduct preparedness activities for SRH prior to the pandemic, and expressed that this was a gap that should be addressed moving forward. Several development INGO respondents opined that actors working in development settings do not yet think of preparedness as being part of their scope of work, or relevant in stable settings.

However, respondents consistently reported that lack of preparedness was a critical gap, and emphasized that the COVID-19 pandemic has demonstrated that preparedness, including for SRH, should be a priority for all settings.

Coordination also played an important role in facilitating organizations' response to COVID-19 in settings across the humanitarian-development nexus. Respondents across organizations and settings reported that coordination supported stakeholders to advocate for the prioritization of contraceptive and SRH services in COVID-19 response; mitigate supply chain disruptions to address stockouts and maintain service continuity; and ensure service delivery coverage. Respondents reported that coordination was particularly effective in settings where stakeholders had existing relationships, and where robust coordination mechanisms were operating prior to the onset of the pandemic—illustrating the importance of building partnerships between humanitarian and development stakeholders from the local to international level.

Respondents from organizations working in both humanitarian and development settings cited the need to strengthen coordination across the nexus as an important lesson learned from their experience providing contraceptive services during the pandemic. Respondents reflected that the number of countries experiencing fragility is steadily mounting, and the distinctions between humanitarian and development settings are fading—rendering humanitarian and development silos archaic and inefficient.

In this vein, the COVID-19 pandemic has reinforced the imperative to restructure humanitarian systems and funding architectures to invest in local actors and locally led humanitarian response.

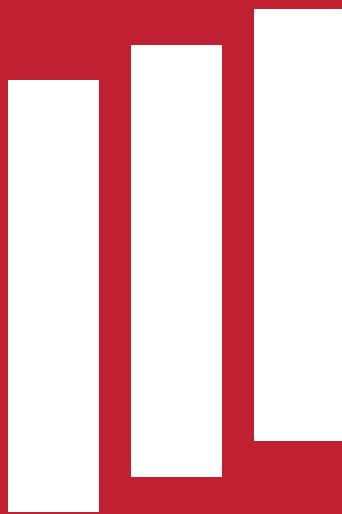
Conclusion

COVID-19 has amplified the need for humanitarian assistance on a global scale, and the full economic and social fallout of the pandemic in settings across the humanitarian-development nexus is not yet clear. Perhaps now more than ever, stakeholders across the nexus must work together to maximize the impact of humanitarian aid and combat fragility, including by investing in and implementing emergency preparedness for SRH, and protecting and ensuring access to lifesaving contraceptive services. Contraception is an investment in the rights, health, and well-being of girls and women. By harnessing the lessons learned during the COVID-19 pandemic, stakeholders can improve women's and girls' right to access contraception across the full range of humanitarian and development settings by building resilient health systems, inclusive of SRH, that can withstand and adapt to shocks.



Acronyms and abbreviations

CERF	Central Emergency Response Fund
DMPA-SC	Depot medroxyprogesterone acetate, sub-cutaneous (brand name Sayana Press)
ECPs	Emergency contraceptive pills
HIPs	High Impact Practices for Family Planning
IGBV	Gender-based violence
ARH kit	Inter-Agency Emergency Reproductive Health Kit
INGO	International nongovernmental organization
IUD	Intrauterine device
KII	Key informant interview
LARC	Long-acting reversible contraception
MISP	Minimum Initial Service Package
NGO	Nongovernmental organization
OCP	Oral contraception pill
PPE	Personal protective equipment
STI	Sexually transmitted infection
UN	United Nations
WHO	World Health Organization
WRC	Women's Refugee Commission.



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